# EXHIBIT 2

UNITED STATES DISTRICT COURT

FOR THE CENTRAL DISTRICT OF CALIFORNIA

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|---|---|
| MARK SNOOKAL, an individual,<br><br>Plaintiff,<br><br>vs.<br><br>CHEVRON USA, INC., a California Corporation, and DOES 1 through 10, inclusive,<br><br>Defendants. | Case No.<br>2:23-cv-6302-HDV-AJR |

REPORTER'S TRANSCRIPT

VIDEOTAPED DEPOSITION OF

DR. VICTOR ADEYEYE

VOLUME 2

Tuesday, April 22, 2025

Via Zoom Video Conferencing

6:00 a.m.

Reported by: Rachel N. Barkume, CSR, RMR, CRR
Certificate No. 13657

A P P E A R A N C E S

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THE VIDEOGRAPHER:

Cliff Gonshery

ALSO PRESENT:

Eguono Erhun, Chevron Nigeria Limited

why maybe, maybe not. Alleviating the symptoms medically does not equate to addressing the dissection, the tearing. That's what I mean by that.

BY MS. FLECHSIG:

Q. What can you do to alleviate the symptoms of the dissection?

A. Give some peripheral beta blockers.

Q. And what does that do for someone?

A. What's that?

Q. Yeah. What does that do for someone who's had a dissection?

A. That would reduce the symptoms of pain, excruciating pain, that individual would be having.

Q. Okay. Does it -- does it slow their risk of death from occurring while they await surgery?

Or does it have any other benefits?

A. No. No. It confers no benefit of survival on such individual.

Q. Understood. Okay.

Have you ever treated a patient whose dilated aortic root has dissected?

A. None of note.

Q. Okay. Sorry, you said "none of note."

There's -- there's none that you have treated?

A. No. No. None.
Q. Okay. Have you ever treated someone with a dilated aortic root that ruptured?
A. No.
Q. Okay. Okay. I want to ask about Mark Snookal, the plaintiff in this lawsuit.
Have you reviewed the complaint in this lawsuit?
A. How?
Q. Just -- yeah, have you reviewed the actual complaint of the lawsuit, so at any time --
A. I'm not -- I'm not privy to that document.
Q. Okay. When did you first hear the name Mark Snookal?
A. 2019.
Q. Okay. And how did you -- how did you hear about him?
A. Via e-mail communication between myself and the occupational health unit; Dr. Femi Pitan, you mentioned, Dr. Asekomeh, Dr. Henry Aiwuyo.
Q. I'm sorry. Who was the third one that you said?
A. Via e-mail communication --
Q. Oh --
A. -- with myself and the occupational health

So if I'm to rephrase it, "How often do they ask me for cardiac-related issue," depends on what they have. I can't put a number or a frequency to how often they confer me for cardiac-related issue.

Please note, the patient medevac, one patient I mentioned to you, came from their site of the company from the field to the onshore Warri Hospital. Thank you.

BY MS. FLECHSIG:

Q. Okay. What's your best estimate of how often you consult with them on a cardiac medical issue?

A. I would say two per month when there are gray areas around there during their screening processes.

Q. Okay. So, in other words, when they're screening someone for fitness for duty for a location near you in -- in Warri or around there?

A. Thank you. Yeah.

Q. Okay. Have you ever spoken with Mark Snookal?

A. No. Mark Snookal is not my patient. I had no medical consultation with Mark Snookal. All I had, Mark Snookal, was an advisory role stemming from the occupational health. Not my patient. Medical consultation is different from advisory role.

Q. Okay. Have you ever spoken with anyone who was a treating physician for Mark Snookal?

A. No. The occupational health unit is not a treating physician for Mark Snookal.

Q. Okay. Have you ever reviewed Mark Snookal's employment history with Chevron or otherwise?

MS. FAN: Objection. Vague and ambiguous.

THE WITNESS: It's -- I have only the cardiovascular portion of his investigation, not history. Medical consultation either physical or virtual is divided broadly into three major aspects: History taking, physical or clinical examination, and investigation.

Now, for me, it is that investigation aspect; I only saw just the cardiac one. So I cannot claim to know medical history or employment history of Mark Snookal. I don't know if I'm clear.

BY MS. FLECHSIG:

Q. Yeah. I understand. Thank you. Thank you, Doctor. Okay. I'm going to pull up a document. I'll mark this as Exhibit A.

(Exhibit A marked for identification.)

BY MS. FLECHSIG:

Q. It's been produced as CUSA000768 through 770. And, Dr. Adeyeye, I'm going to share my screen so you can see it and have an opportunity to review it.

Are you able to see Exhibit A, Dr. Adeyeye?

A. Yes, I can see.

Q. Okay. I'm going to scroll to the bottom.

MS. FAN: And, Dr. Adeyeye, if you need to take some time to review the document, I'm sure counsel would be willing to scroll up and down as you need.

BY MS. FLECHSIG:

Q. Absolutely. So I'm here at the bottom of the document, CUSA000770. So here, it looks like there's a July 30th, 2019, e-mail from Dr. Asekomeh to Dr. Pitan with a CC to NIGEC Staff Physicians. I'm going to scroll up. So looks like on August 5th, 2019, Dr. Asekomeh e-mailed to you, Dr. Adeyeye, with a CC to Dr. Aiwuyo and Dr. Pitan.

Are you seeing this e-mail, Dr. Adeyeye?

A. Yes, I can see the e-mail.

Q. Okay.

A. I am -- I'm aware of this, but I was not aware of that first one, the one from Asekomeh to Pitan.

Q. Okay. So this -- this e-mail you received from Dr. Asekomeh here --

A. Yes.

Q. -- at the top of 770?

A. Yes. Yes.

Q. Okay. Okay. And it looks like Dr. Asekomeh's

asking you to weigh in on a few things, potential complications and the likelihood of progression --

A. Yes.

Q. -- management of these complications, possible instructions to communicate to employee as per preventing complications.

A. Yes.

Q. So this looks like a true and correct copy of an e-mail you received back on August 5th, 2019?

A. Yes.

MS. FAN: Objection. Leading. Vague and ambiguous.

BY MS. FLECHSIG:

Q. Is -- sorry, is that a "yes"?

A. That's an e-mail to me by -- from Dr. Asekomeh.

Q. Right. And it looks -- it looks correct; you recall this e-mail?

A. I recall that e-mail from Dr. Asekomeh to me, Dr. Adeyeye, asking me to make comments on those three points.

Q. Okay. I'm going to continue scrolling up to 769 here and to 768.

So Dr. Aiwuyo sends this e-mail to you and Dr. Asekomeh with a CC --

A. Yes.

Q. -- to Dr. Pitan?
A. Yes.
Q. And it looks like Dr. Aiwuyo makes some impressions on Mark Snookal's case.
A. Yes.
Q. I understand you said Dr. Aiwuyo is a part of the occupational health department; correct?
A. Yes.
Q. Do you know -- is he also a cardiologist?
A. Yes.
Q. Okay. Does Dr. Aiwuyo still work in the occupational health division, to your knowledge?
A. No. No.
Q. He no longer works there?
A. He's no longer working there.
Q. Okay. Do you know whether he still works -- like, does work for Chevron Nigeria?
A. Not at all.
MS. FAN: Objection.
BY MS. FLECHSIG:
Q. Okay. And I just want to give you an opportunity to read through this e-mail from Dr. Aiwuyo.
Have you had a chance to read through the e-mail?
A. Yes. Go on.

Q. Okay. It looks like Dr. Aiwuyo linked this article here.

Is -- are you familiar with what the article says?

MS. FAN: Objection. Vague and ambiguous.

THE WITNESS: Mrs. Olivia, be more specific, please, in your questioning, please.

BY MS. FLECHSIG:

Q. Sure.

A. Yes.

Q. Sure. No problem. I guess -- I guess -- you know, did you read -- when you received this e-mail from Dr. Aiwuyo, did you read the article that he linked?

A. Yes. I click on the link, and I read the article from which he extracted the information. Thank you.

Q. Okay. Understood. Did you do anything to search for any other articles that might have been applicable to Mark Snookal's cardiology condition -- cardiac condition?

A. You mean do I do my own literature search?

Q. Correct. Yeah.

Did you look for other articles --

A. Sure, yes.

Q. -- in response to --

A. Yes.
Q. -- Mark Snookal --
A. Yes.
Q. Okay.
A. Yes.
Q. Okay. What did you do to look for those articles?
A. Hello? Excuse me?
Q. Oh, sorry. We must have cut out for a moment. What did you do to look for those articles or the medical research that could pertain to Mark Snookal's cardiac condition?
A. All I did was to look at the current update as of 2019, what literature says on aortic dilatation management so I can give an informed opinion, which was captured in my e-mail as response to this. I'm sure you'll see --
(Reporter clarification.)
THE WITNESS: I read those documents. I make my own search for me to have an informed opinion based on medical literature. And that was captured in my e-mail response, which is -- yes.
BY MS. FLECHSIG:
Q. Okay. Let's go there next.
A. Yes.

Q. So we're at the top of Exhibit A now.
A. Yes, that's my response. That's the summary of my own search.
Q. Okay. So there's this August 5th, 2019, e-mail, and this is your summary of your research; correct?
A. Yeah. Yeah. Yes.
Q. Okay. There's -- is there anything that you know today that would change your opinion of what you expressed in that August 5th, 2019, e-mail?
A. I don't get your question, please. Again, please. Repeat again, please.
Q. Oh, I'm sorry. I think my internet -- apologies. Yeah.
I just was asking is the opinion you expressed in this August 5th, 2019, e-mail -- is that consistent still with your opinion today of Mark Snookal's cardiac condition?
A. Very consistent. Very consistent.
Q. Okay. So you said that you undertook some research to inform this opinion.
What did you do to find -- what did you do to research?
A. First of all, I search for such cases in Nigeria, and that brought me to a publication I was part

of the author; 2,501 echocardiographic studies for individuals with heart conditions. I mean 2,501 cardiac patients, what did we find out is their cardiac condition. Why is that so? That is so, for me, to have an idea how many of such cases do we see in real life.

And I found out that it's quite very rare. This publication, which I'm part of the author, is available -- can be made available to you. Out of 2,501, no such case, and that tells you the reality of the condition, the limited cases of such condition to warrant physicians' experience.

Then I also found out that most of those cases were from autopsy, not in real life. I look at literature and I saw that, oh, even for those cases being found, they were found at autopsy. Those are local cases. And I also look at a U.S. study between 1999 and 2016, then; the epidemiology of fatal ruptured aortic aneurysms in the United States. Epidemiology of fatal ruptured aortic aneurysms in the United States, 1999 to 2016.

This also gives me an idea how much of mortality is still with this condition. So putting all these things together, I was able to have my own opinion; which, looking at literature from 2019 to now, they say the same; and I am able to advise, as put in

this, my write-up, on such cases. Thank you.

Q. Okay. Thank you for that. I just wanted to clarify.

How many -- how many studies did you review? It sounds like there were two. Or am I missing some?

A. Okay. Two local studies. I can remember one now. And one foreign study. The foreign study is the one in United States, 1999 to 2016, epidemiology of fatal ruptured aortic aneurysms in United States, 1999 to 2016. The local one I remember vividly was an article I also am part of the co-authors, the 2,501 cases echocardiographic studies done in the Southwestern Nigeria. This can be made available to you if you are so interested, or you can go online and search there. Thank you.

Q. Okay. So the local study using 2,051 echocardiographic studies --

A. 2,501. '501.

Q. 2,501?

A. '01. '501, yes.

Q. Sorry. Okay. 2,501 local studies.

You said it's reviewing that number of echocardiographic studies; correct?

A. Yes.

Q. But it's not specifically on people with

dilated aortic roots; it's just echocardiographic studies generally; correct?

A. Yes. That's a sample study showing us that that condition is rare. If you do echo on 2,501 individual and cannot have one case, that tells you it's quite rare. And the available local studies of such cases are at postmortem, autopsy, and that gives a lot of clinical information. Thank you.

Q. Understood.

(Reporter clarification.)

BY MS. FLECHSIG:

Q. The postmortem studies, is -- strike that.

So you said of the 2,501 echocardiographic studies done locally, none of those showed patients with a dilated aortic root; correct?

A. Correct. Correct.

Q. Okay. Is it fair to say that dilated aortic roots are more rare in Nigeria than in the United States?

A. You cannot say that because we've not actually compare region to region. What we can say is most cases are found at autopsy.

Q. Understood.

A. Because patients don't often live to warrant such evaluation for treatment and what have you. I

don't know if I'm getting my point. So it takes high index of suspicion and a standard screening methods for you to dictate. But any country where autopsy is top notch, you can see more of such.

Q. Understood. Did any of the studies you referred to refer to a patient's risk of mortality when they do have a dilated aortic root?

A. Mortality is over 90 percent.

Q. So -- okay. So let me clarify.

You referred to -- the studies referred to someone with a dilated aortic root having a 90 percent risk of mortality?

A. Over 90 percent risk of mortality.

Q. Is that a risk of mortality once they have suffered a dissection or rupture?

A. That is once they have suffered a dissection or rupture.

Q. Okay.

A. The mortality --

Q. I am so sorry. Go ahead.

A. In other words, when they suffer a dissection or rupture; the chance, the likelihood of that is over 90 percent.

Q. Understood. Which of the studies that you cited referred to that statistic?

A. Some of the local studies revealed before my submission.

Q. Okay. Did any of the studies you referred to discuss the overall risk of a rupture or dissection occurring when someone has a dilated aortic root?

A. The risk of rupture or dissection is done based on those centers, those regions that were able to pool patient with aortic dilatation, and they were able to put some theory to measure the risk. Like I told you, in our setting, it is not a common occurrence.

If I are to do 2,501 echocardiography, and I cannot find one, so how many will I do to have a sizable number to apportion risk? I don't know if I'm clear on that.

Q. Yeah, I think so. What I'm trying to understand is, I guess, did you refer to anything that gave you a sense of how often someone with a dilated aortic root has a rupture or a dissection?

A. Yes. Yes. Some of them in that e-mail link, if you click on them and read, you will see the Western literatures studying the risk of dissection, the risk of rupture, and the attendant mortality related.

Q. In the -- you're referring to the University of Calgary article that Dr. Aiwuyo linked to?

A. Those links.

did he have symptoms?" I hope I've been able to clear that. Thank you.

Q. Okay. So is it fair to say, then, given the knowledge you had at the time, you did not know whether or not Mr. Snookal was having symptoms of an aneurysm?

A. Excellent.

Q. Okay. What are symptoms of an aortic aneurysm, if you know?

A. Generally speaking, symptoms of aortic aneurysm includes chest pain, difficulty with breathing, occasionally some fainting spell. Other additional symptoms, if it's progressive, include, like, nausea, vomiting, and signs or symptoms of systemic shock when the ruptures occur. These are things that are time-bound from the patient.

Q. Understood. When you reviewed the literature to evaluate Mr. Snookal's risk of a dissection or rupture occurring, did you refer to any studies that discuss the relative -- the risk relative to the size of the dilation?

A. Yes.

Q. And that's the University of Calgary study that Dr. Aiwuyo cited?

A. Yes.

Q. Okay. Any other studies that you were able to

find that would evaluate that specific risk of a serious cardiac event occurring?

A. Fortunately or unfortunately, such rare conditions fall into what we'll call guideline-directed therapy or management, in which case we have a unified guideline for such cases. And these guidelines are pulled out of multiple experiences, multiple cases have been seen, and they be able to come up with one guideline. I mean the whole Canada, the whole U.S. could have one guideline made by the expats for such cases. So that becomes applicable.

In Nigeria where I practice, of course, we are limited by such cases -- such cases, so I cannot say, oh, I will look at that guideline of the risk associated with such dimension of ease. Thank you.

Q. Understood. Thank you, Doctor. Okay. I want to show you Exhibit B. So in Exhibit A, it -- you know, Dr. Asekomeh, it sounds like, attaches a medical report and a cardiologist report from April 2019. Exhibit B -- here, let me share my screen first.

(Exhibit B marked for identification.)

BY MS. FLECHSIG:

Q. Exhibit B has been produced as CUSA000775.

Are you able to see my screen, Mr. -- excuse

me, Dr. Adeyeye?

A. I can see your screen. I can see it.

Q. Okay. Is this the medical report that -- that Dr. Asekomeh sent you attached to the e-mail we reviewed earlier today?

A. No, no, no, no. This is a classified information for only the occupational health team, not for any cardiologist for their opinion. What cardiologist only look for is the ECG, echocardiogram, plus or minus computed tomographic angiography, not all these details of liver function, kidney functions, QuantiFERON, and all that. We are not privy to all this.

This is their own field. It is a submission of what they get from specialists that inform them writing this. And that's why I answer you earlier, I'm not privy to his full history. And I've given you the three buckets of medical consultation. Thank you.

Q. Understood. So you did not have an opportunity --

A. Huh-uh, huh-uh.

Q. -- to review this before making an evaluation of Mr. Snookal's cardiac condition.

A. At all. At all. At all.

MS. FAN: Objection. Argumentative.

THE WITNESS: I do not need the full story, as written here, to offer cardiologist opinion. I do not need patient history, I do not need patient liver function or renal function, as captured in that report, to offer my cardiologist opinion. Because if you look at the guideline, the guideline are so specific, and they are made based on the case at hand, not based on the exposure to tuberculosis, full blood count, genotype, urine result, no.

They are made based on an individual with an ECG like this, an individual with an echo report like this, and a individual with a CTA like this, as a cardiologist, what is our opinion, what is our stand, and we give it as such. Regardless of all that, of a previous cholecystectomy, of a previous tooth extraction, of a previous ear piercing, those are not issues for us to make our own informed decision. And that is the practice in cardiology.

BY MS. FLECHSIG:

Q. Understood. Thank you, Doctor. So let me show you what I'm marking as Exhibit C.

(Exhibit C marked for identification.)

BY MS. FLECHSIG:

Q. This has been produced as CUSA000818 through

822.

Dr. Adeyeye, I believe this is -- this is a cardiology report on Mark Snookal; correct?

MS. FAN: Objection. Calls for speculation.

THE WITNESS: How do I know the qualification of the person? How do I know the person and the qualification? What I just see -- oh, attending cardiology, S Khan, M.D. That's the name.

BY MS. FLECHSIG:

Q. Yeah. I understand. I guess what I'm asking is just -- is this the cardiology report on Mark Snookal that you reviewed back in 2019?

A. No. No. No. No. A cardiologist opinion is a blinded opinion. Please note, a cardiologist opinion is a blinded opinion, meaning that you're not privy to what A is saying, you're not privy to what B is saying, you're not privy to what C is saying, you are to make your own opinion.

And for these two, three opinion, an informed decision could be made. I'm not supposed and I don't look at or they don't give this to make an opinion. So for me, I wasn't privy to this document as of that time. What I only made my opinion based on is ECG, like I said before, echocardiograph, like I said before, and a CTA, computer tomographic angiography.

Those are the things I needed to make an informed opinion, not all these report by somebody else who made his own opinion, probably after medical consultation. You can only write like this after medical consultation, not when you are seeking your advisory role. I hope that is clear.

Q. Understood. So you did not feel it was relevant to review Mr. Snookal's treating cardiologist's impressions of his cardiac conditions?

MS. FAN: Objection. Argumentative. Vague and ambiguous.

THE WITNESS: I don't need to know what Mr. Snookal's attending cardiologist write before I make my own opinion. Same way any other cardiologist in any part of the world tells me that a patient has congenital cardiac failure with ejection fraction of 30 to 40 percent, Dr. Adeyeye, what is the chance of this person dying within one year -- six months to one year? I can give you my value without even knowing the name or the gender of that person.

That is the way cardiologists go about work. It is data, evidence-based, not all of this, what was the height, what was the weight, what's the BMI, does he smoke, does he take alcohol -- no. These are facts that I've been saying. Patient with heart failure, ejection

fraction 40 percent, are likely to die --

(Reporter clarification.)

THE WITNESS: -- 50 percent of them --

(Reporter clarification.)

THE WITNESS: -- within six months to one year.

(Reporter admonishment.)

BY MS. FLECHSIG:

Q. Okay. The -- I understand you said you reviewed three scans of Mr. Snookal's hearts -- of his heart. Excuse me.

Of those scans, were they all from 2019.

A. Yes. That's why this comes -- he presented to them for screening or what have you -- for pre-employment screening. It's ECG, echo, and CTA.

Q. Okay. Understood. And you were not able to view whether the results of those scans changed or were stable over time for Mr. Snookal?

A. I said it over and over. Medical consultation is different -- totally different from medical advisory role. Looking at those things, whether they've changed, whether they were there or not, requires medical consultation of me with Mr. Snookal, not somebody asking me for advisory role on Mr. Snookal. Those are two different things.

Please, let's tease this out so that this question can be more specific and the answer to be more specific. We are bringing in too many things on the table now. Please.

Q. Yeah. I think I understand, Doctor. I guess, just, what I'm asking is: You only viewed one set of his scans from one point in time; correct?

A. I was given his cardiac investigation results and to make an advisory statement on that cardiac investigation results. Thank you.

Q. And the cardiac investigation results were not based off of scans over time of Mark Snookal; correct?

A. They were based on what he presented to them at the occupational health unit.

Q. Okay. So did the occupational health unit share with you Mark Snookal's scans over time?

A. No. I was only privy to what he presented to them that they seek my opinion on. That's all.

Q. Understood. Okay. Did you -- so other than the e-mail that we reviewed together, did you discuss Mr. Snookal's cardiac condition in any other communications, whether that's orally, in real time, over the phone, anything like that?

A. All we did was exchange of e-mail, so from me to the team in occupational health, and the e-mail train

CERTIFICATE OF STENOGRAPHIC REPORTER

I, RACHEL N. BARKUME, a Certified Shorthand Reporter of the State of California, hereby certify that the witness in the foregoing deposition,

DR. VICTOR ADEYEYE,

was by me duly sworn to tell the truth, the whole truth, and nothing but the truth in the within-entitled cause; that said deposition was taken at the time and place therein named; that the testimony of said witness was stenographically reported by me, a disinterested person, and was thereafter transcribed into typewriting.

Pursuant to Federal Rule 30(e), transcript review was requested.

I further certify that I am not of counsel or attorney for either or any of the parties to said deposition, nor in any way interested in the outcome of the cause named in said caption.

DATED: May 6, 2025.

Rachel N. Barkume

Rachel N. Barkume, CSR No. 13657, RMR, CRR

[redacted]

**From:** ADEYEYE, VICTOR [DELOG MEDICAL SERVICES] <DNOY@chevron.com>
**Sent:** Monday, 5 August 2019 17:55
**To:** Aiwuyo, Henry [SERVITICO] <henryaiwuyo@chevron.com>; Asekomeh, Eshiofe [DELOG] <EAEV@chevron.com>
**Cc:** Pitan, Olorunfemi (femi.pitan) <femi.pitan@chevron.com>
**Subject:** RE: Snookal, Mark- Medical report

Sir/Ma,

I agree with Dr Aiwuyo submissions on above employee, especially the precautionary measures highlighted which we need to further reiterate to our client.

I have a little concern about his choice of anti-hypertensives (Losartan and Amlodipine). Guideline-directed management recommends Beta-blockers like Carvedilol, Bisoprolol as part of his blood pressure control meds with a systolic BP target of less than 120mmHg (Thoracic aortic aneurysm and documented runs of premature ventricular complexes).
It will be nice if this is brought to the attention of his physician.

Kind regards,

Victor.

---

**From:** Aiwuyo, Henry [SERVITICO] <henryaiwuyo@chevron.com>
**Sent:** Monday, August 5, 2019 2:26 PM
**To:** Asekomeh, Eshiofe [DELOG] <EAEV@chevron.com>; ADEYEYE, VICTOR [DELOG MEDICAL SERVICES] <DNOY@chevron.com>
**Cc:** Pitan, Olorunfemi (femi.pitan) <femi.pitan@chevron.com>
**Subject:** RE: Snookal, Mark- Medical report

Good day,

With regards to this expert, 47years old employee with CT and ultrasound evidence of Thoracic aortic aneurysm,

It was documented in the report that he has aortic dilatation of 4.4cm on ECHCARDIOGRAPHY,

however CT aortography which is a more accurate imaging modality revealed a maximum value of 4.2cm max at the aortic root and 4.1cm max at the descending thoracic aorta.

From the Canadian guidelines these values appear low risk for a major adverse CV event. Some have used values of <4.5cm as partition value for low risk situations., link below refers.

https://www.ucalgary.ca/FTWguidelines/content/aortic-aneurysm

it is expected that every aneurysm must be subjected to 6months- 1year assessment to ascertain the rate of progression (>1cm is an indication for repair). I feel there should be a concrete plan by his home cardiologist for this

evaluation.

Below are my response to the questions put forward:

1. Complications associated with aneurysms include

    a. Rupture/dissection ( sudden and catastrophic) and its attendant sequala
    b. Thromboembolic phenomenon
    c. Pressure symptoms on other vital organs
    d. Sudden death

2. In Escravos unfortunately we are only limited to initial stabilization and transfer of such high risk CV complications if any occurs. In the unlikely event of any of the aforementioned complications, we may not be able to support
   such an individual due to our peculiarities.

3. Instructions for the patient

   -avoid lifting heavy objects
   -quit smoking (if he is a smoker)
   -manage hypertension strictly, there is need to aim for lower targets <120mmhg systolic (DOC beta blockers)
   -watch out for alarm symptoms like pain in the chest (throbbing, tearing, aching or sharp pain, often sudden), pain in the back, nausea, vomiting, fainting, and systemic shock
   -avoid moderate to high intensity exercises as much as possible

I made effort to search the MEP if there are clear cut field guidelines for patient with aortic aneurysm, unfortunately I found none. What is established is that a patient with symptomatic aneurysm should not be allowed to work in an offshore location.

I am still open to further discussions on this sir.

Warm regards.

***DR. AIWUYO, HENRY***
***OH Physician/Cardiologist***
***EGTL clinic***
***EXT-77943***
***B2B dr oyebowale olaniyi***
***"as to diseases, make a habit of two things- to help, or at least, to do no harm"***
***hippocrates***

**From:** Asekomeh, Eshiofe [DELOG] <EAEV@chevron.com>
**Sent:** Monday, August 5, 2019 11:43 AM
**To:** ADEYEYE, VICTOR [DELOG MEDICAL SERVICES] <DNOY@chevron.com>
**Cc:** Aiwuyo, Henry [SERVITICO] <henryaiwuyo@chevron.com>; Pitan, Olorunfemi (femi.pitan) <femi.pitan@chevron.com>
**Subject:** FW: Snookal, Mark- Medical report

Good day,

Below mail trail refers. Kindly help evaluated medical documents and attached Cardiologist report for above named EE who is coming to Escravos from the USA. His job description is- Reliability Engineering Manager.
Kindly review around the following key points:

1. Potential complications and the likelihood of progression
2. Management of these complications even if only initial intervention vis-à-vis available care level in Escravos
3. Possible instructions to communicate to employee as per preventing complications.

Thanks for your usual help.

Warm regards,

Eshiofe Asekomeh

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**From:** Asekomeh, Eshiofe [DELOG]
**Sent:** Tuesday, July 30, 2019 7:44 PM
**To:** Pitan, Olorunfemi (femi.pitan) <femi.pitan@chevron.com>
**Cc:** NIGEC Staff Physicians (l9esc300) <L9ESC300@chevron.com>
**Subject:** Snookal, Mark- Medical report

Good day Ma,

I will like to discuss Mark Snookal (Manager, Reliability Engineering) with you tomorrow. He is on transfer from El Segundo, USA to Escravos, Nigeria on international assignment.
He has aortic root dilatation and was reviewed by a Cardiologist April this year. The examining Physician in the US had declared him fit with limitation (not to lift weight above 50 pounds)
Attached are the medical reports and the Cardiologist report from April, 2019.

Warm regards,

Eshiofe Asekomeh

**Dr. Asekomeh E.G**
**Chevron Hospital**
**Warri, Nigeria**

**MEDICAL SUMMARY**

**RE: SNOOKAL MARK DOB-** [redacted]

Above named 47-year old employee is on international transfer from El Segundo, USA to Escravos, Nigeria for international assignment as a Reliability Engineering Manager. He had his medical Suitability for Expatriate Assignment (MSEA) evaluation on the 24th of July 2019.

Significant/ relevant medical history gleaned from his GO-146 include;

-History of being hypertensive and presently on Lorsatan and amlodipine- date of diagnosis/ date of commencement and dosages not stated.

- He exercises regularly for at least thirty minutes at three times a week on average

- He is a non-smoker

- A past medical history of treatment for depression between 1994 and 1996

- He had a cholecystectomy in 2014

- A significant history of diagnosis of asymptomatic dilated aortic root and premature ventricular complexes on ECG for which the Cardiologist recommended no additional treatment.

Main findings on examination was a bradycardia with pulse rate of 53/min and blood pressure of 135/78mmHg.

Review of recent investigations revealed:

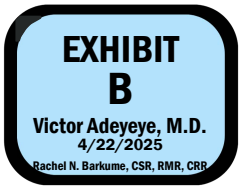
1. ECG: Heart rate of 47/min, sinus rhythm with PVC, left atrial deviation and slight intraventricular delay
2. Slightly borderline elevated triglyceride and LDL cholesterol and reduced HDL cholesterol
3. Normal E/U/Cr, LFT, CBC and urine analysis
4. Negative Quantiferon TB test

Transthoracic echocardiography done on 9th of April 2019 revealed aortic root diameter of 4.4 cm with normal aortic arch size.

CT Angiography done on the 10th of April 2019 also reported a stable aortic arch (Compared to an earlier CT angiography done on 10th of May 2017) with a diameter of 4.2cm and a maximum size of the ascending aorta of 4.1cm.

Dr. Asekomeh E.G

7/08/2019



**CAI - MVZM** **Name: Snookal, Mark Sex: M** 07-30-2019 07:31pm
**GUID - 1000444873** **DOB: 04-13-1972 Age: 47**
**US - MVZM**
**MANUFACTURING - MVZM**

**Doc ID: 4913728 Revision # 0 D.O.S: 04-03-2019** **Continued...**
**Author: 0000** **Location:**
**Revised by: White, Ghada S** **Create Date: 07-29-2019 03:56pm**
**Type: Progress Note**
**Subject: Cardiology Report**

**KAISER PERMANENTE**



LOS ANGELES MEDICAL CNTR L
4867 W. SUNSET BLVD.
LOS ANGELES CA 90027-5969

Snookal, Mark J
MRN: 000004554567, DOB: 4/13/1972, Sex: M
Visit date: 4/3/2019

Order Providers

| Authorizing | Encounter | Billing |
|---|---|---|
| Khan, Shahid Hameed (M.D.) | Khan, Shahid Hameed (M.D.) | Khan, Shahid Hameed (M.D.) |

Order Information

| Date | Department | Ordering/Authorizing |
|---|---|---|
| 4/3/2019 | CARDIOLOGY | Khan, Shahid Hameed (M.D.), M.D. |

Associated Diagnoses

**AORTIC ANEURYSM**
**AORTIC VALVE REGURGITATION**

Result Information

Status: Final result (Collected: 4/10/2019 08:57) Provider Status: Reviewed

Result Notes for CTA CARDIAC W CONTRAST, WO QUANTITATIVE CALCIUM

**Notes recorded by Khan, Shahid Hameed (M.D.), M.D. on 4/11/2019 at 11:35 AM PDT**
Call Center Nurses: Please let patient know that his Aorta looks stable on his recent CT scan. No change in aortic size.

CTA Aorta 4/10/2019:
Aortic root is stable at 4.2 cm. Maximal size of ascending thoracic aorta is 4.1 cm. Compared to 5/16/17 there has been no significant Change

Electronically signed by,

S. KHAN MD
Attending Cardiologist, Division of Cardiology, SCPMG
Clinical Associate Professor, UCLA School of Medicine
Ph: 323-783-4585
4/11/2019
11:35 AM

4/10/2019 10:28 AM - Interface, Scal_Radiology

Narrative

CT1/4 â€" PREFER MON/WED PROTOCOL: GATED AORTA.

Lab and Collection

CTA CARDIAC W CONTRAST, WO QUANTITATIVE CALCIUM - 4/3/2019

Result History

CTA CARDIAC W CONTRAST, WO QUANTITATIVE CALCIUM on 4/10/2019

Transcription

| Type | ID | Date and Time | Dictating Provider |
|---|---|---|---|
| Diagnostic imaging | 86769685 | 4/10/2019 10:28 AM | Hsu, Joe Yo (M.D.), M.D. |

Signed by Hsu, Joe Yo (M.D.), MEDICAL DOCTOR on 04/10/19 at 1028

CARDIAC CTA: 4/10/19

KAISER PERMANENTE

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Snookal, Mark J
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Visit date: 4/3/2019

HISTORY: 46-year-old male with aortic regurgitation and aortic root enlargement.

TECHNIQUE: Cardiac CTA is performed following administration of 130 ml of IV contrast material.

As required by California law, the CTDIvol and DLP radiation doses associated with this CT study are listed below. This represents the estimated dose to a standard lucite phantom resulting from the technique used for this study, but is not the dose to this specific patient.

Type / CTDIvol / DLP / Phantom
Chest / 5.55 / 136.04 / B
Chest / 16.46 / 8.23 / B
Chest / 17.39 / 365.11 / B
Total Exam DLP: 509.38
CTDIvol = mGy DLP = mGy-cm
Phantom: B=Body32, H=Head16

QUALITY: Fair, arrhythmia with PVCs

COMPARISONS: CTA 5/126/17, 5/26/16, 4/21/15

FINDINGS:

AORTA: Left arch with normal branching of great vessels. Normal ductus bump.

AORTIC VALVE: 3 cusps without calcification.

Aortic measurements are as follows:

AORTIC ANNULUS: 2.1 x 3.5 cm
AORTIC ROOT: 4.2 cm (average of 3 measurements from convexity to commissure)
SINO-TUBULAR JUNCTION: 3.7 x 3.8 cm
ASCENDING AORTA AT LEVEL OF RIGHT PULMONARY ARTERY: 3.9 x 4.1 cm
AORTIC ARCH: 2.7 x 3.0 cm (proximal to origin of left subclavian artery)
DESCENDING AORTA AT LEVEL OF RIGHT PULMONARY ARTERY: 2.7 x 2.9 cm
ABDOMINAL AORTA AT HIATUS: 2.5 x 2.6 cm

OTHER FINDINGS: Lungs are clear. No acute airspace disease. No

KAISER PERMANENTE

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Visit date: 4/3/2019

effusion or consolidation seen. No mediastinal or hilar lymphadenopathy. Visualized upper abdomen show cholecystectomy.

IMPRESSION:

Aortic root is stable at 4.2 cm. Maximal size of ascending thoracic aorta is 4.1 cm.

Compared to 5/16/17 there has been no significant change.

This report electronically signed by Joe Hsu, MD on 4/10/2019 10:23 A

Display only: Transcription (86769685) on 4/10/2019 10:28 AM by Hsu, Joe Yo (M.D.), M.D.

Order Providers

| Authorizing | Encounter | Billing |
|---|---|---|
| Khan, Shahid Hameed (M.D.) | Lockerbie, Colin S | SCAL PROVIDER |

Order Information

| Date | Department | Released By | Authorizing |
|---|---|---|---|
| 4/9/2019 | CARDIOLOGY | Lockerbie, Colin S | Khan, Shahid Hameed (M.D.), M.D. |

Original Order

| Ordered On | Ordered By |
|---|---|
| 4/9/2019 3:25 PM | Lockerbie, Colin S |

Associated Diagnoses

AORTIC VALVE REGURGITATION

Result Information

Status: Final result (Collected: 4/9/2019 15:32) Provider Status: Reviewed

4/16/2019 2:02 PM - Interface, Scal_Results_A

Component
REPORT

KAISER PERMANENTE

LOS ANGELES MEDICAL CNTR L
4867 W. SUNSET BLVD.
LOS ANGELES CA 90027-5969

Snookal, Mark J
MRN: 000004554567, DOB: 4/13/1972, Sex: M
Visit date: 4/9/2019

4/16/2019 2:02 PM - Interface, Scal_Results_A (continued)

Conclusions

Summary
Technically very difficult study.
NSR with frequent PVCs.

Normal left ventricular wall thickness. Mildly increased left ventricular size and normal systolic function with an estimated ejection fraction of 55-60%. Indeterminate diastolic function.
Upper normal left atrial size. Mild right atrial enlargement.
Upper normal right ventricular size and systolic function.

Structurally normal mitral valve without stenosis. Trace mitral regurgitation.
Structurally normal trileaflet aortic valve. Mild to moderate eccentric aortic regurgitation. No aortic stenosis. Aortic regurgitant pressure half-time is 524 ms.
Aortic root measures 4.4 cm. Normal aortic arch size.

Findings
Mitral Valve
Structurally normal mitral valve without stenosis. Trace mitral regurgitation.
Aortic Valve
Structurally normal trileaflet aortic valve. Mild to moderate eccentric aortic regurgitation. No aortic stenosis. Aortic regurgitant pressure half-time is 524 ms.
Tricuspid Valve
Cannot reliably estimate right ventricular systolic pressure (RVSP).
Pulmonic Valve
The pulmonic valve leaflets are thin and pliable; valve motion is normal.
Mild pulmonic regurgitation is present.
Left Atrium
Upper normal left atrial size.
Left Ventricle
Normal left ventricular wall thickness. Mildly increased left ventricular size and normal systolic function with an estimated ejection fraction of 55-60%. Indeterminate diastolic function.
Right Atrium
Mild right atrial enlargement.
Right Ventricle
Upper normal right ventricular size and systolic function.
Pericardial Effusion
No pericardial effusion.

Aorta
Aortic root measures 4.4 cm. Normal aortic arch size.
Miscellaneous
IVC diameter is = 2.1 cm with a > 50% inspiratory collapse, suggestive of a right atrial pressure of 0-5 mmHg.

Signature

Electronically signed by LEBOWITZ, STEPHEN HOWARD MD(Interpreting physician) on 04/16/2019 02:01 PM

** Note: For images and the full report use the "PACS Images" link below **

**CAI - MVZM** **Name: Snookal, Mark Sex: M** **07-30-2019 07:31pm**
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Visit date: 4/9/2019

4/16/2019 2:02 PM - Interface, Scal_Results_A (continued)

Linked Documents

View Image

Lab and Collection

TRANSTHORACIC ECHO REAL TIME W 2D IMAGE, SPECTRAL AND COLOR FLOW DOPPLER COMPLETE - 4/9/2019

Result History

TRANSTHORACIC ECHO REAL TIME W 2D IMAGE, SPECTRAL AND COLOR FLOW DOPPLER COMPLETE on 4/16/2019

**END OF REPORT**